Credit / Debit Card Payment Authorization Form

Sign and complete this form to authorize Clinical Behavior Analysis to make debits to your credit/debit card listed below for cost shares, copays, or subscriber fees per the subscriber's insurance plan. By signing this form you give us permission to debit your account for the amount indicated on or after the indicated date. This is permission for transactions only related to your insurance session copays & cost shares as outlined by your insurance plan and does not provide authorization for any unrelated debits or credits to your account.

Please complete the information below:

Patient Name:_____

I _____ authorize Clinical Behavior Analysis to charge my credit /debit card account indicated
(full name)

below on or after date of service was rendered only for CBA Services.

Billing Address_____ Phone# _____

City, State, Zip _____ Email _____

Account Type: ☐ Visa ☐ MasterCard ☐ AMEX ☐ Discover Other: _____

Cardholder Name _____

Account Number _____

Expiration Date _____ 3-Digit Code: _____ (this code is above signature on back of card)

SIGNATURE: DATE:

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above, and is valid for copays and cost shares as outlined by my insurance plan. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form and the payment policy.